

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/15/2012  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>155106 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                       |  | X3) DATE SURVEY<br>COMPLETED<br>07/27/2012 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>RIVERWALK VILLAGE |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>295 WESTFIELD RD<br>NOBLESVILLE, IN 46060 |  |  |                            |
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| F0000   | <p>This visit was for a Recertification and State Licensure survey. This visit included the investigation of Complaints IN00110360 and IN00111398.</p> <p>Complaint IN00110360: Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00111398: Unsubstantiated due to lack of evidence.</p> <p>Survey dates: July 23, 24, 25, 26, and 27, 2012</p> <p>Facility number: 000044<br/>Provider number: 155106<br/>AIM number: 100274940</p> <p>Survey team:<br/>Janet Stanton, R.N.--Team Coordinator<br/>Heather Lay, R.N. (7/23, 24, 25, 26)<br/>Melanie Strycker, R.N.</p> <p>Census bed type:<br/>SNF/NF--145<br/>Total--145</p> <p>Census payor type:<br/>Medicare--15<br/>Medicaid--100<br/>Other--30<br/>Total--145</p> |  |  | F0000  | <p>The creation and submission of this Plan of Correction does not constitute an admission by this Provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This Provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a desk review for paper compliance in lieu of post survey visit on or after August 26, 2012</p> |  |                            |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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|   | <p>Sample: 24</p> <p>These deficiencies reflect State findings<br/>cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 8/2/12<br/>Cathy Emswiller RN</p> |  |  |  |  |  |                            |

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| F0157<br>SS=D   | <p>483.10(b)(11)<br/>NOTIFY OF CHANGES<br/>(INJURY/DECLINE/ROOM, ETC)<br/>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to report an allegation of alleged sexual abuse to a resident's physician. The deficient practice affected 1 of 1 resident reviewed for alleged</p> | F0157  | F157 Notification of Changes - It is the consistent practice of this Provider to report any and all allegations of abuse to the residents physician.1. What corrective action will be | 08/26/2012   |  |  |  |

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|   | <p>sexual abuse violations in a sample of 24 residents reviewed. [Resident #55]</p> <p>Findings include:</p> <p>1. On 7/23/12 at 11:05 A.M., tour of the facility was initiated with the Assistant Director of Nursing [ADoN].</p> <p>At that time, Resident #55 was identified as having behaviors such as refusal of care and medications.</p> <p>On 7/24/12 at 4:00 P.M., Resident #55's record was reviewed. Diagnoses included, but were not limited to, schizophrenia, dementia, depression, anxiety, and hallucinations.</p> <p>A "Behavior Care Plan" dated 5/29/12, included, but was not limited to, "Problem Start Date: 5/29/12... Behavior: Resident has delusions about others. Resident believes that other people who are not present call her names... Goal: Resident will have no signs or symptoms of delusions or false perceptions... Approach with date of 5/29/12: Staff will approach calmly, offer drink, take resident to her room to eliminate external stimulus, refer to MD when necessary for medication evaluation, and staff will offer resident a snack..."</p> |  | <p>accomplished for those residents found to have been affected by the alleged deficient practice? Resident #55 physician was notified of this resident's statements.2. How will this Provider identify other residents being affected by the same alleged deficient practice?All residents making any statement of allegation of abuse regardless of true, false, mental status or diagnosis can be affected by the alleged deficient practice.Any residents making such allegations will be investigated per policy with physician notification.3. What measures will be put into place and/or what sytematic changes will be made to ensure that the alleged deficient practice does not recur?The charge nurse who immediately was told by staff of this allegation went to Resident #55 and questioned this resident about the allegation. Resident #55 stated that she did make the allegation however was only kidding to get the staff's attention. The charge nurse was re-educated of facility abuse policy by Staff Development coordinator to properly report any allegation to the Executive Director and to other officials - including the resident physician - in accordance with state law.All staff were re-educated 8-14-12 on the facility abuse policy by DNS/Staff Development Coordinator to ensure proper investigation and reporting of all</p> |  |  |  |  |

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|   | <p>A quarterly, "Minimum Data Set" assessment, dated 7/10/12, included, but was not limited to, "Brief Interview Mental Status: 10 [moderate cognitive impairment]..."</p> <p>An event, dated 7/21/12 at 5:54 A.M., initiated by Licensed Practical Nurse [LPN]#5, indicated Resident #55 stated a Certified Nursing Assistant [CNA] molested her. The event indicated family was not notified and the immediate intervention implemented was to attend to Resident #55's needs promptly.</p> <p>No documentation was located in the resident's clinical record regarding notification of the resident's physician.</p> <p>On 7/25/12 at 3:30 P.M., the facility investigation of the alleged sexual abuse of Resident #55 was requested from the Administrator and DoN.</p> <p>On 7/26/12 at 9:30 A.M., the facility investigation was provided by the DoN.</p> <p>At that time, in an interview, the DoN, indicated the incident was not reported to ISDH because Resident #55 changed her story regarding the allegation of abuse. Also, the DoN indicated LPN #5 did not notify the Administrator or on-call Nursing Supervisor of the incident.</p> |  |  |  | <p>incidents are followed per policy and in accordance with state laws. ED and/or DNS will ensure allegations are properly reported to residents physician.4. How will the corrective action be monitored to ensure the alleged deficient practice does not recur? To ensure ongoing and consistent compliance, the DNS and/or designee is responsible for completion the Change in Condition (physician notification) and Abuse CQI audit tool. This audit will occur weekly for 4 weeks, then bi-monthly for 2 months and quarterly until compliance is consistently met and maintained for at least 6 months. The results of these audits will be reviewed by the CQI committee. If the results of 100% is not achieved, the committee will create an action plan to ensure ongoing compliance.</p> |  |                            |

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|   | <p>However, the Social Service Director [SSD] started the investigation on 7/21/12, no time given.</p> <p>The investigation included, but was not limited to:</p> <p>A written statement from the SSD, dated 7/21/12, no time, included, but was not limited to, "Met with resident [Resident #55] this date. SS was notified about resident's allegation that she told staff that she was molested by a nurse aide. Per staff, resident later stated that she just said that to get staff's attention... Resident confirmed she says things to get people's attention... Per resident, resident has a difficult time distinguishing reality versus delusions... per resident's sister, she makes things up..."</p> <p>The resident's sister or legal representative was notified at an unknown date or time per the above written statement from the SSD.</p> <p>A written statement from the DoN, dated 7/24/12, no time, included, but was not limited to, "Follow up to comment made by [Resident #55] to 2 CNAs on 7/21/12... While providing care to this resident she made the comment that she had been molested. The CNAs [not identified in investigation] reported this to</p> |  |  |  |  |  |                            |

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|   | <p>their charge nurse [LPN #5]... This nurse went immediately to the resident and asked her what had occurred... The resident stated that her statement regarding being molested wasn't true... She just wanted up and the CNAs were not moving fast enough for her... The buddy system is utilized when providing care to [Resident #55] as she frequently makes false statements... Additionally, the video was reviewed and it confirmed that both CNAs went into [Resident #55's] room to provide care and that no one other than [LPN #5] had entered the room... Residents were interviewed for the purpose of determining similar behavior... No other residents expressed any issues in this regard... The Unit Manager interviewed the staff and confirmed that the statement was made to the CNAs while providing [Resident #55's] care on the night of 7/21/12 and that both were present with the resident as required by the resident care sheet and the care plan..."</p> <p>2. On 7/23/12 at 1:00 P.M., the facility abuse policies and procedures were provided by the facility Administrator.</p> <p>The abuse policies and procedures included, but were not limited to, "Resident Abuse... The Executive Director and/or Director of Nursing will</p> |  |  |  |  |  |  |

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|   | <p>be notified... the physician will be notified<br/>and orders will be received for treatment<br/>and/or discharge based upon<br/>assessment..."</p> <p>3.1-5(a)(2)</p> |  |  |  |  |  |                            |

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| F0225<br>SS=D   | <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4)<br/>INVESTIGATE/REPORT<br/>ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to report an allegation of</p> |  |  | F0225  | F225 Investigation / Report / Allegations / Individuals - It is the consistent practice of this                          |  | 08/26/2012                 |

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|   | <p>alleged sexual abuse immediately to the facility Administrator, Director of Nursing, or Nurse Supervisor, and to State Agencies. The deficient practice affected 1 of 1 residents reviewed for alleged sexual abuse violations from a sample of 24 residents reviewed. [Resident #55]</p> <p>Findings include:</p> <p>On 7/23/12 at 11:05 A.M., tour of the facility was initiated with the Assistant Director of Nursing [ADoN].</p> <p>At that time, Resident #55 was identified as having behaviors such as refusal of care and medications.</p> <p>On 7/24/12 at 4:00 P.M., Resident #55's record was reviewed. Diagnoses included, but were not limited to, schizophrenia, dementia, depression, anxiety, and hallucinations.</p> <p>A "Behavior Care Plan" dated 5/29/12, included, but was not limited to, "Problem Start Date: 5/29/12... Behavior: Resident has delusions about others. Resident believes that other people who are not present call her names... Goal: Resident will have no signs or symptoms of delusions or false perceptions... Approach with date of 5/29/12: Staff will</p> |  | <p>Provider to report any allegation of abuse immediately to the Administrator, Director of nursing, or Nurse supervisor and to state agencies.1. What Corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?Resident #55 made an allegation of abuse to her c.n.a's which in return immediately told their supervisor - the charge nurse. The supervisor charge nurse immediately investigated this allegation by interviewing resident #55. The resident stated that she did make the allegation but that she was only kidding to get the staff attention and agreed statements like this should not be made unless true. The charge nurse properly ensured resident #55 was free from abuse by immediately investigating her allegation. Further investigation was completed by the ED, DNS and social service to validate that no abuse occurred and further validated this was a consistent behavior with resident #55 making false statements as indicated in her care plan. The charge nurse was re-educated on this Provider abuse policy to properly investigate and report to the proper officials as required by policy and in accordance with law. The physician and family were also notified to discuss the allegation. If this resident reports any further allegations of</p> |  |  |  |  |

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|   | <p>approach calmly, offer drink, take resident to her room to eliminate external stimulus, refer to MD when necessary for medication evaluation, and staff will offer resident a snack..."</p> <p>A quarterly, "Minimum Data Set" assessment, dated 7/10/12, included, but was not limited to, "Brief Interview Mental Status: 10 [moderate cognitive impairment]..."</p> <p>An event, dated 7/21/12 at 5:54 A.M., initiated by LPN #5, indicated Resident #55 stated a C.N.A. molested her. The event indicated family was not notified and the immediate intervention implemented was to attend to Resident #55's needs promptly.</p> <p>A progress notes, dated 7/21/12 at 6:02 A.M., indicated Resident #55 stated a C.N.A. [not identified in the abuse investigation] molested her; however, when LPN #5 interviewed the resident, Resident #55 indicated the allegation was not true.</p> <p>There was no documentation that the facility Administrator, Director of Nursing [DoN], or nursing supervisor was immediately notified.</p> <p>On 7/25/12 at 3:30 P.M., the facility</p> |  | <p>such, the allegation will be immediately investigated and reported per policy.2. How will this Provider identify other residents being affected by the same alleged deficient practice? All residents making any allegation of abuse could be affected by the alleged deficient practice.Any residents that allegations of abuse will be reported to ED and or DNS for proper investigation and reporting per policy.3. What measures will be put into place and/or what systematic changes will be made to ensure that the alleged deficient practice does not recur? The charge nurse, who immediately was told by her staff of this allegation, went to resident #55 and inquired about the allegation. Resident #55 stated that she did make the allegation, however was only kidding to get staff's attention. The charge nurse was re-educated of the facility abuse policy to properly report any and all allegations to the Executive Director and to other officials in accordance with the state laws.All staff were re-educated 8-14-12 on the facility abuse policy by Staff Development Coordinator to ensure identification, proper investigation and reporting of all incidents are followed per policy and in accordance with state laws.Residents who alledge abuse will have a complete investigation initiated. Staff will</p> |  |  |  |  |

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|   | <p>investigation of the alleged sexual abuse of Resident #55 was requested from the Administrator and DoN.</p> <p>At that time, in an interview, the DoN indicated Resident #55 changed her story [regarding being molested] immediately upon LPN #5 interviewing her. In addition, the DoN indicated Resident #55 had a history of making false statements and a history of false perceptions.</p> <p>On 7/26/12 at 9:30 A.M., the facility investigation was provided by the DoN.</p> <p>At that time, in an interview, the DoN, indicated the incident was not reported to ISDH because Resident #55 changed her story regarding the allegation of abuse. Also, the DoN indicated LPN #5 did not notify the Administrator or on-call Nursing Supervisor of the incident. However, the Social Service Director [SSD] started the investigation on 7/21/12, no time given.</p> <p>The investigation included, but was not limited to:</p> <p>A written statement from the SSD, dated 7/21/12, no time, included, but was not limited to, "Met with resident [Resident #55] this date. SS was notified about resident's allegation that she told staff that</p> |  | <p>report allegations of abuse to their immediate supervisor. ED/DNS will be notified immediately. ED will review each allegation to ensure reporting to all appropriate agencies is initiated per isdh guidelines and to ensure investigation is complete. All allegations of abuse, neglect and / or misappropriation of property will be reviewed by IDT team to ensure proper investigation and reporting is completed.4. How will the corrective action be monitored to ensure the alleged deficient practice does not recur?To ensure ongoing and consistent compliance, the DNS and/or designee is responsible for completion the Abuse CQI audit tool. This audit will occur weekly for 4 weeks, then bi-monthly for 2 months and quarterly until compliance is consistently met and maintained for 6 months. The results of these audits will be reviewed by the CQI committee. If the results of 100% is not achieved, the committee will create an action plan to ensure ongoing compliance.</p> |  |  |  |  |

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|   | <p>she was molested by a nurse aide. Per staff, resident later stated that she just said that to get staff's attention... Resident confirmed she says things to get people's attention... Per resident, resident has a difficult time distinguishing reality versus delusions... per resident's sister, she makes things up..."</p> <p>A written statement from the DoN, dated 7/24/12, no time, included, but was not limited to, "Follow up to comment made by [Resident #55] to 2 C.N.A.s on 7/21/12... While providing care to this resident she made the comment that she had been molested. The C.N.A.s [not identified in investigation] reported this to their charge nurse [LPN #5]... This nurse went immediately to the resident and asked her what had occurred... The resident stated that her statement regarding being molested wasn't true... She just wanted up and the C.N.A.s were not moving fast enough for her... The buddy system is utilized when providing care to [Resident #55] as she frequently makes false statements... Additionally, the video was reviewed and it confirmed that both C.N.A.s went into [Resident #55's] room to provide care and that no one other than [LPN #5] had entered the room... Residents were interviewed for the purpose of determining similar behavior... No other residents expressed</p> |  |  |  |                            |  |  |

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|   | <p>any issues in this regard... The Unit Manager interviewed the staff and confirmed that the statement was made to the C.N.A.s while providing [Resident #55's] care on the night of 7/21/12 and that both were present with the resident as required by the resident care sheet and the care plan..."</p> <p>The facility failed to immediately report the incident to the facility Administrator, DoN, or Nursing Supervisor, and failed to report to ISDH.</p> <p>3.1-28(c)</p> |  |                     |  |  |  |  |

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| F0226<br>SS=D   | <p>483.13(c)<br/>DEVELOP/IMPLMENT ABUSE/NEGLECT,<br/>ETC POLICIES<br/>The facility must develop and implement<br/>written policies and procedures that prohibit<br/>mistreatment, neglect, and abuse of<br/>residents and misappropriation of resident<br/>property.</p> <p>Based on record review and interview, the<br/>facility failed to ensure their Abuse<br/>Prohibition Policies were followed related<br/>to reporting alleged sexual abuse to the<br/>Administrator, Director of Nursing, or<br/>Supervisor, and State agencies. The<br/>deficient practice affected 1 of 1 resident<br/>reviewed for alleged sexual abuse<br/>violations in a sample of 24 residents<br/>reviewed. [Resident #55]</p> <p>Findings include:</p> <p>1. On 7/23/12 at 11:05 A.M., tour of the<br/>facility was initiated with the Assistant<br/>Director of Nursing [ADoN].</p> <p>At that time, Resident #55 was identified<br/>as having behaviors such as refusal of<br/>care and medications.</p> <p>On 7/24/12 at 4:00 P.M., Resident #55's<br/>record was reviewed. Diagnoses<br/>included, but were not limited to,<br/>schizophrenia, dementia, depression,<br/>anxiety, and hallucinations.</p> |  | F0226               | <p>F226 Development / Implement /<br/>Abuse / Policies - It is the<br/>consistent practice of this<br/>Provider to implement and follow<br/>Abuse prohibition policies related<br/>to reporting to appropriate<br/>parties.1. What Corrective action<br/>will be accomplished for those<br/>residents found to have been<br/>affected by the alleged deficient<br/>practice?Resident #55 made an<br/>allegation of abuse to her c.n.a's<br/>which in return immediately told<br/>their supervisor - the charge<br/>nurse. The supervisor charge<br/>nurse immediately investigated<br/>this allegation by interviewing<br/>resident #55. The resident stated<br/>that she did make the allegation<br/>but that she was only kidding to<br/>get the staff attention and agreed<br/>statements like this should not be<br/>made unless true. The charge<br/>nurse properly ensured resident<br/>#55 was free from abuse by<br/>immediately investigating her<br/>allegation. Further investigation<br/>was completed by the ED, DNS<br/>and social service to validate that<br/>no abuse occurred and further<br/>validated the consistent<br/>behavior of Resident #55 making<br/>false statements as indicated in<br/>her care plan. The charge nurse</p> |  | 08/26/2012                                 |  |

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|   | <p>A "Behavior Care Plan" dated 5/29/12, included, but was not limited to, "Problem Start Date: 5/29/12... Behavior: Resident has delusions about others. Resident believes that other people who are not present call her names... Goal: Resident will have no signs or symptoms of delusions or false perceptions... Approach with date of 5/29/12: Staff will approach calmly, offer drink, take resident to her room to eliminate external stimulus, refer to MD when necessary for medication evaluation, and staff will offer resident a snack..."</p> <p>A quarterly, "Minimum Data Set" assessment, dated 7/10/12, included, but was not limited to, "Brief Interview Mental Status: 10 [moderate cognitive impairment]..."</p> <p>An event, dated 7/21/12 at 5:54 A.M., initiated by LPN #5, indicated Resident #55 stated a CNA molested her. The event indicated family was not notified and the immediate intervention implemented was to attend to Resident #55's needs promptly.</p> <p>A progress notes, dated 7/21/12 at 6:02 A.M., indicated Resident #55 stated a CNA [not identified in the abuse investigation] molested her; however, when LPN #5 interviewed the resident,</p> |  | <p>was re-educated on this Provider abuse policy to properly investigate and report to the proper officials as required by policy and occordane with law. The physician and family were also notified to discuss the allegation.2. How will this Provider identify other residents being affected by the same alleged deficient practice?All residents making any allegation of abuse could be affected by the alleged deficient practice.Any residents that allegegations of abuse will be reported to ED and or DNS for proper investigation and reporting per policy.3. What measures will be put into place and/or what systematic changes will be made to ensure that the alleged deficient practice does not recur? The charge nurse, who immediately was told by her staff of this allegation, went to resident #55 and inquired about the allegation. Resident #55 stated that she did make the allegation, however was only kidding to get staff's attention. The charge nurse was re-educated of the facility abuse policy to properly report any and all allegations to the Executive Director and to other officials in accordance with the state laws.All staff were re-educated on the facility abuse policy to ensure identification, proper investigation and reporting of all incidents are followed per policy and in accordance with</p> |  |  |  |  |

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|   | <p>Resident #55 indicated the allegation was not true.</p> <p>There was no documentation that the facility Administrator, Director of Nursing [DoN], or nursing supervisor was immediately notified.</p> <p>On 7/25/12 at 3:30 P.M., the facility investigation of the alleged sexual abuse of Resident #55 was requested from the Administrator and DoN.</p> <p>At that time, in an interview, the DoN indicated Resident #55 changed her story [regarding being molested] immediately upon LPN #5 interviewing her. In addition, the DoN indicated Resident #55 had a history of making false statements and a history of false perceptions.</p> <p>On 7/26/12 at 9:30 A.M., the facility investigation was provided by the DoN.</p> <p>At that time, in an interview, the DoN, indicated the incident was not reported to ISDH because Resident #55 changed her story regarding the allegation of abuse. Also, the DoN indicated LPN #5 did not notify the Administrator or on-call Nursing Supervisor of the incident. However, the Social Service Director [SSD] started the investigation on 7/21/12, no time given.</p> |  | <p>state laws. Residents who alledge abuse will have a complete investigation initiated. Staff will report allegations of abuse to their immediate supervisor. ED/DNS will be notified immediately. ED will review each allegation to ensure reporting to all appropriate agencies is initiated per isdh guidelines and to ensure investigation is complete. All allegations of abuse, neglect and / or misappropriation of property will be reviewed by IDT team to ensure proper investigation and reporting is completed.4. How will the corrective action be monitored to ensure the alleged deficient practice does not recur?To ensure ongoing and consistent compliance, the DNS and/or designee is responsible for completion the Abuse CQI audit tool. This audit will occur weekly for 4 weeks, then bi-monthly for 2 months and quarterly until compliance is consistently met and maintained for 6 months. The results of these audits will be reviewed by the CQI committee. If the results of 100% is not achieved, the committee will create an action plan to ensure ongoing compliance.</p> |  |  |  |  |

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|   | <p>The investigation included, but was not limited to:</p> <p>A written statement from the SSD, dated 7/21/12, no time, included, but was not limited to, "Met with resident [Resident #55] this date. SS was notified about resident's allegation that she told staff that she was molested by a nurse aide. Per staff, resident later stated that she just said that to get staff's attention... Resident confirmed she says things to get people's attention... Per resident, resident has a difficult time distinguishing reality versus delusions... per resident's sister, she makes things up..."</p> <p>A written statement from the DoN, dated 7/24/12, no time, included, but was not limited to, "Follow up to comment made by [Resident #55] to 2 CNAs on 7/21/12... While providing care to this resident she made the comment that she had been molested. The CNAs [not identified in investigation] reported this to their charge nurse [LPN #5]... This nurse went immediately to the resident and asked her what had occurred... The resident stated that her statement regarding being molested wasn't true... She just wanted up and the CNAs were not moving fast enough for her... The buddy system is utilized when providing</p> |  |  |  |  |  |                            |

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|   | <p>care to [Resident #55] as she frequently makes false statements... Additionally, the video was reviewed and it confirmed that both CNAs went into [Resident #55's] room to provide care and that no one other than [LPN #5] had entered the room... Residents were interviewed for the purpose of determining similar behavior... No other residents expressed any issues in this regard... The Unit Manager interviewed the staff and confirmed that the statement was made to the CNAs while providing [Resident #55's] care on the night of 7/21/12 and that both were present with the resident as required by the resident care sheet and the care plan..."</p> <p>The facility failed to immediately report the incident to the facility Administrator, DoN, or Nursing Supervisor, and failed to report to ISDH.</p> <p>2. On 7/23/12 at 1:00 P.M., the facility abuse policies and procedures were provided by the facility Administrator.</p> <p>The abuse policies and procedures included, but were not limited to, "Sexual Abuse: includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault... All abuse allegations/abuse must be reported to the Executive Director immediately, and to</p> |  |                     |  |  |  |  |

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|   | <p>the resident's representative within 24 hours of the report... Failure to report will result in disciplinary action, up to and including immediate termination... The Executive Director/designee will report all unusual occurrences, which include abuse, within 24 hours of discovery, to the Long Term Care Division of the Indiana State Department of Health..."</p> <p>3.1-28(a)</p> |  |  |  |  |  |                            |

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| F0314<br>SS=D   | <p>483.25(c)<br/>TREATMENT/SVCS TO PREVENT/HEAL<br/>PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the brief of Resident #72 was removed in a way that reduced the potential for skin damage caused by shearing or friction. This deficient practice affected 1 of 6 residents reviewed who had pressure sores, in a sample of 24.</p> <p>Findings include:</p> <p>In an interview during the initial orientation tour on 7/23/12, at 10:50 A.M., L.P.N. #4 indicated Resident #72 had a pressure sore on her coccyx and that Resident #72 had acquired the pressure sore while residing at the facility.</p> <p>On 7/23/12, at 2:20 P.M., the clinical record for Resident #72 was reviewed. Diagnoses included, but were not limited to, hypertension, anxiety, dementia, chronic obstructive pulmonary disease,</p> |  | F0314               | <p>F314 Treatment / Prevent / Heal Pressure sores - It is the consistent practice of this Provider to ensure residents who have pressure sores receives necessary treatment and services to promote healing and prevention of new sores developing.1. What Corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?This event with the state surveyor occurred on 7-25-12. Resident #72 skin was assessed to ensure no negative outcome occurred with this alleged practice. On 7-27-12, Resident #72 area was assessed and identified as completely healed with no skin issues related to this alleged finding.2. How will this Provider identify other residents being affected by the same alleged deficient practice? All residents with wounds have the potential to be affected by the alleged practice.Nursing staff were re-educated on the</p> |  | 08/26/2012                                 |  |

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|   | <p>esophageal reflux, Alzheimer's dementia, chronic kidney disease, and heart failure.</p> <p>An Event Note dated 7/20/12, indicated that Resident #72 had an "existing" area measuring 0.5 cm x 0.1 cm x 0.1 cm to her coccyx and that the open area was a stage III.</p> <p>On 7/25/12, at 10:25 A.M., a dressing change was observed for Resident #72. L.P.N. #3 was observed to remove the resident's brief by pulling the brief out from under the resident, pulling on the skin and causing friction. A dressing was observed over the coccyx area. L.P.N. #3 was observed to remove the dressing. Under the dressing a small open area was observed to be covered with ointment. The wound area was pink in color.</p> <p>On 7/27/12, at 10:40 A.M., L.P.N. #4 provided a policy titled, "Incontinent Brief - Application." This policy included, but was not limited to, the following: "Unfasten and remove brief resident is currently wearing."</p> <p>During an interview at this same time, L.P.N. #4 indicated the normal practice for removing a brief is to roll the brief with the soiled side in; continue to roll the brief, pushing the brief under the resident; roll the resident over the brief, and</p> |  | <p>incontinent care, brief application and removal by the Staff Development coordinator 8-14-12.3. What measures will be put into place and/or what systematic changes will be made to ensure that the alleged deficient practice does not recur? LPN #4 was provided re-education by the Staff Development Coordinator related to the proper removal of briefs from a resident with return demonstration. Nursing staff were re-educated on the incontinent care, brief application and removal by the Staff Development coordinator 8-14-12. Nursing staff were provided with a skills check off related to brief application and removal.4. How will the corrective action be monitored to ensure the alleged deficient practice does not recur? To ensure ongoing and consistent compliance, the DNS and/or designee is responsible for completion of the Pressure Wounds - Treatment CQI audit tool. This audit will occur weekly for 4 weeks, then bi-monthly for 2 months and quarterly until compliance is consistently met and maintained for 6 months. The results of these audits will be reviewed by the CQI committee. If the results of 95% is not achieved, the committee will create an action plan to ensure ongoing compliance.</p> |  |  |  |  |

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|   | remove the brief from the opposite side.<br><br>3.1-40(a)(2)   |  |                     |  |  |  |  |

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| F0371<br>SS=F   | <p>483.35(i)<br/>FOOD PROCURE,<br/>STORE/PREPARE/SERVE - SANITARY<br/>The facility must -<br/>(1) Procure food from sources approved or<br/>considered satisfactory by Federal, State or<br/>local authorities; and<br/>(2) Store, prepare, distribute and serve food<br/>under sanitary conditions</p> <p>Based on observation, interview, and<br/>record review, the facility failed to<br/>properly store and handle food in 1 of 1<br/>kitchen, and 1 of 5 dining rooms. This<br/>deficient practice had the potential to<br/>affect 142 of 145 residents who consume<br/>food prepared in the facility kitchen. In<br/>addition, the facility failed to provide<br/>sanitary storage for a resident's individual<br/>cans of supplement by storing them on the<br/>resident's floor. This deficient practice<br/>affected 1 of 1 resident reviewed for<br/>supplement use in a sample of 24<br/>residents reviewed. [Resident #47]</p> <p>Findings include:</p> <p>1. On 7/23/12 at 10:15 A.M. to 10:45<br/>A.M., initial tour of the kitchen was<br/>initiated with the Dietary Manager [DM].</p> <p>During that time, the following was<br/>observed in the walk-in refrigerator:</p> <p>A. 11 trays filled with small bowls of<br/>mixed fruit and 1 tray with bowls of ready</p> |  | F0371               | <p>F371 Store Food / Prepare /<br/>Sanitary - It is the consistent<br/>practice of this Provider to<br/>properly store and handle food<br/>under sanitary conditions.1.<br/>What Corrective action will be<br/>accomplished for those residents<br/>found to have been affected by<br/>the alleged deficient practice?A.<br/>all bowls were properly covered<br/>and in sanitary conditions prior to<br/>serving.B. Container of pineapple<br/>was properly dated with use by<br/>date.C. Cottage cheese<br/>containers were properly<br/>discarded.E. 3 items of 1 gallon<br/>liquids were properly<br/>discarded.F. Container of apple<br/>sauce was properly discarded.G.<br/>The tray of filled cups were<br/>properly covered and dated prior<br/>to servingH. The tray of filled<br/>cups were properly covered and<br/>dated prior to serving.I. The<br/>bananas were discarded and not<br/>used in serving.J. 2 boxes of<br/>noodles were stored in sanitary<br/>conditions; however they were<br/>moved lower so they would not be<br/>within 12 inches from the<br/>ceiling.K. the Tray of cookies and<br/>pies were properly covered and<br/>dated for proper service for</p> |  | 08/26/2012                                 |  |

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|   | <p>to serve salad. The 12 trays were open to air and 4 of 12 trays lacked a use by date or preparation date.</p> <p>B. One large clear container of pineapple without a use by date or preparation date.</p> <p>C. 2 open cottage cheese [5 pound containers] 3/4 empty without an open or use by date.</p> <p>D. 2 large metal containers and 1 smaller metal container of prepared food without identification or a use by date or preparation date. [The DM indicated 2 were egg salad and 1 mashed potatoes prepared that day for lunch service].</p> <p>E. 1 gallon each of 3 different liquids open to air without identification, and not dated with use by or preparation date. [The DM indicated the liquids were apple, prune, and orange juice].</p> <p>F. 1 clear container of apple sauce without a secured lid and without a use by or preparation date.</p> <p>G. 1 tray of 30 small cups of liquid without identification or use by or preparation date. [The DM identified as nectar thick water and nectar thick cranberry juice].</p> |  |  |  | <p>residents.(3) resident #47 supplement cans were not individually on the floor. The cans were in a cardboard case preventing any cans from touching the floor. The case was moved from the floor to a shelf.(4) Dietary aide #1 was removed from the schedule until her hand properly healed and could work without an ace wrap. All dietary staff were provided with hairnets that properly covered entire head of hair.(8)the pitchers made and served daily per residents request was labeled and properly served.2. How will this Provider identify other residents being affected by the same alleged deficient practice?All residents utilizing food and drink service from this Providers kitchen have the potential to be affected by the alleged deficient practice. Dietary staff were re-educated by the Registered Dietician regarding proper hand washing, proper use of hair nets, food dating and food service under proper sanitary conditions3. What measures will be put into place and/or what systematic changes will be made to ensure that the alleged deficient practice does not recur?Items identified were properly corrected with dates, covers and properly stored and served in sanitary conditions. Dietary staff were re-educated by the Registered Dietician regarding proper hand washing, proper use of hair nets, food</p> |  |                            |

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|   | <p>H. 1 tray of 30 small cups of liquid stored on the walk-in refrigerator floor without identification or use by or preparation date. Same as above.</p> <p>The following was observed in the dry storage area:</p> <p>I. 2 boxes of bananas were located on the floor.</p> <p>J. 2 boxes of extra wide egg noodles were located on the top storage shelf less than 12 inches from the ceiling.</p> <p>The following was observed in the kitchen area:</p> <p>K. 1 rolling rack was observed to have 7 trays of cookies [in plastic wrap] with individual cups of pudding [not covered, open to air] and 1 tray of 2 pies [not covered, open to air].</p> <p>2. On 7/23/12 at 10:25 A.M., in an interview, the DM indicated he was aware there was a concern with labeling and proper covering of food with his dietary staff. He indicated he has been inservicing all staff regarding proper labeling and storage of food.</p> <p>3. On 7/23/12 at 11:05 A.M., tour of the facility was initiated with the Assistant</p> |  | <p>storage, food dating and food service are all completed under proper sanitary conditions. Dietary manager and/or designee will do daily rounds to ensure kitchen service is completed within proper sanitary conditions in relationship with items inserviced. 4. How will the corrective action be monitored to ensure the alleged deficient practice does not recur? To ensure ongoing and consistent compliance, the Dietician and/or Dietary Manager is responsible for completion both the Sanitation Review and the Handwashing CQI audit tool. These audits will occur weekly for 4 weeks, then bi-monthly for 2 months and quarterly until compliance is consistently met and maintained for 6 months. The results of these audits will be reviewed by the CQI committee with action plans completed with failed threshold.</p> |  |  |  |  |

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|   | <p>Director of Nursing [ADoN].</p> <p>Resident #47 was identified as receiving hospice services. At that time, Resident #47's room was observed with 3 flats of individual cans of 2 calorie HN [supplement] stored on the resident's floor.</p> <p>In an interview on 7/23/12 at 11:45 A.M., the ADoN indicated the hospice agency provided the supplement and stored them on the resident's floor. She indicated she would remove from the floor and place in the cabinet.</p> <p>4. On 7/24/12 at 4:30 P.M., observation of food preparation of the evening meal was conducted.</p> <p>At that time, 6 kitchen staff were observed with hairnets that did not cover all their hair.</p> <p>On 7/24/12 at 4:45 P.M., Dietary Aide #1 and Dietary Aide #2 were observed setting up to serve in the facility's Moving Forward unit.</p> <p>Dietary Aide #1 was observed to have an ace wrap on her left hand/wrist area. She was observed setting up the steam table.</p> <p>Dietary Aide #1 was not observed</p> |  |  |  |                            |  |  |

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|   | <p>washing her hands upon entry into the Moving Forward units kitchen area.</p> <p>Dietary Aide #1 was observed preparing a can of soup for a resident without washing her hands.</p> <p>Dietary Aide #2 was observed to wash her hands upon entry into the unit kitchen; however, she left the kitchen to get paper towels for the hand washing sink and failed to re-wash her hands prior to donning gloves to begin serving residents.</p> <p>5. On 7/24/12 at 5:30 P.M., in an interview, the DM indicated he was aware there was a problem with handwashing and he had already discussed the issues with Dietary Aide #1 and Dietary Aide #2. In regard to Dietary Aide #1's injured hand, he indicated she was only able to wash the right hand and he didn't want to tell her not to work. He indicated he would discuss her injury with management.</p> <p>6. On 7/24/12 at 6:00 P.M., in an interview, the Administrator and DoN indicated all employees must be able to wash both hands while working and they would discuss the issue with the DM.</p> <p>7. On 7/26/12 at 12:30 P.M., the facility Administrator provided the policy and</p> |  |  |  |                            |  |  |

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|   | <p>procedures titled, "General Food Preparation and Handling," dated 4/11 and "Food Storage," dated 4/11.</p> <p>The General Food Preparation and Handling policy and procedure included, but was not limited to, " Policy: Food items will be prepared to conserve maximum nutritive value... be free from injurious organisms and substances... Procedure: Food is covered or wrapped for storage..."</p> <p>The Food Storage policy and procedure included, but was not limited to, "Policy: Sufficient storage facilities are provided to keep food safe, wholesome, and appetizing... stored by methods designed to prevent contamination... Procedure: Food items will be stored on shelves... Containers with tight fitting covers must be used... All containers must be accurately labeled and dated... Hands must be washed after unloading supplies or prior to handling any food items... Food is stored a minimum of 6 inches above the floor and 18 inches below the sprinkler heads on clean racks or other clean surfaces..."</p> <p>8. During the general observations of the facility on 7/23/2012, at 2:40 P.M., the</p> |  |  |  |  |  |  |

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|   | <p>main dining room was observed. One pitcher containing a dark liquid and one pitcher containing a yellow liquid were observed on a small table. Neither pitcher contained a label.</p> <p>During an interview at this same time the Administrator indicated these pitchers contained tea and lemonade for the residents.</p> <p>"Retail Food Establishment Sanitation Requirements Title 410 IAC 724" effective 11/13/04 indicates the following:</p> <p>"SEC 191. (a) Except as specified in subsection (d), refrigerated, ready-to-eat, potentially hazardous food prepared and held in a retail food establishment for more than twenty-four (24) hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on one (1) of the temperature and time combinations specified as follows and the day of preparation shall be counted as day one (1):...."</p> <p>3.1-19(f)<br/>3.1-21(i)(2)<br/>3.1-21(i)(3)</p> |  |  |  |  |  |  |

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| F0441<br>SS=E   | <p>483.65<br/>INFECTION CONTROL, PREVENT<br/>SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program<br/>The facility must establish an Infection Control Program under which it -<br/>(1) Investigates, controls, and prevents infections in the facility;<br/>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br/>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection<br/>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br/>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br/>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens<br/>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on interview and record review, the facility failed to ensure a tuberculin skin</p> |  | F0441               | F441 Infection Control / Prevent / Spread - it is the consistent   |  | 08/26/2012                                 |  |

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|   | <p>test for tuberculosis [PPD--Purified Protein Derivative antigen] was administered prior to, or upon, admission for 5 of 6 residents admitted to the facility since the last Recertification survey ending on 6/17/11; and failed to administer an annual tuberculin skin test to 2 residents, in a sample of 24 residents reviewed. [Residents #4, #17, #28, #32, #33, #34, and #201]</p> <p>Findings include:</p> <p>1. The clinical record for Resident #4 was reviewed on 7/23/12 at 2:40 P.M. Diagnoses included, but were not limited to, history of acute respiratory failure, diabetes, history of a cerebral vascular accident [C.V.A.], and morbid obesity.</p> <p>The resident was admitted to the facility on 4/19/12.</p> <p>The facility electronic [computer] health record indicated the admission 1st. Step P.P.D. skin test was administered on 6/7/12 and read on 6/9/12.</p> <p>During the daily conference on 7/24/12 at 3:30 P.M., the Director of Nursing was given the opportunity to submit any documentation demonstrating the resident received a P.P.D. test prior to, or upon, admission.</p> |  | <p>practice of this Provider to ensure a tuberculin skin test for tuberculosis is administered prior to or upon admission.1. What Corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #4 - based on a facility internal audit, this Provider identified this issue and properly corrected by providing this resident with a PPD on 6/7/12. Resident #17 - based on a facility internal audit, this Provider identified this issue and properly corrected by providing this resident with a PPD on 6/5/12. Resident #201 - this resident was given an PPD on 4/21/12. Resident #33, #34, #28, #32 - residents were provided with a PPD2. How will this Provider identify other residents being affected by the same alleged deficient practice? All residents that are admitted and reside in this facility have the potential to be affected by the alleged deficient practice. A facility audit was conducted of all residents to ensure PPD has been properly provided to each resident. Any resident without a PPD has been given and updated to be current with this requirement.3. What measures will be put into place and/or what systematic changes will be made to ensure that the alleged deficient practice does not recur? Nursing staff were re-educated</p> |  |  |  |  |

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|   | <p>In an interview on 7/25/12 at 3:27 P.M., the Director of Nursing indicated the initial/admission P.P.D. was given late.</p> <p>2. The clinical record for Resident #17 was reviewed on 7/26/12 at 11:20 A.M. Diagnoses included, but were not limited to, Parkinson's disease, diabetes, dementia, history of right-side heart failure, and debility.</p> <p>The resident was admitted to the facility on 3/2/12.</p> <p>The facility electronic [computer] health record indicated the admission 1st. Step P.P.D. skin test was administered on 6/5/12 and read on 6/8/12.</p> <p>During the daily conference on 7/26/12 at 3:50 P.M., the Director of Nursing was given the opportunity to submit any documentation demonstrating the resident received a P.P.D. test prior to, or upon, admission.</p> <p>At the final exit on 7/27/12 at 2:20 P.M., the Director of Nursing indicated she had no additional documentation related to a tuberculin skin test prior to, or upon, admission for this resident.</p> <p>3. The closed clinical record for Resident</p> |  |  |  | <p>on the requirements of providing residents with a PPD upon admission. A facility audit was conducted of all residents to ensure PPD has been properly provided to each resident. Any resident without a PPD has been given and updated to be current with this requirement. Each resident upon admission will receive a ppd from the admitting nurse. The IDT team will audit M-F each new admit medical record to ensure PPD properly and timely given. Annual PPD's will be given based on the admit date and yearly following - the medical records nurse has a calendar/roledex determining when each annual ppd is due and when to give them. 4. How will the corrective action be monitored to ensure the alleged deficient practice does not recur? To ensure ongoing and consistent compliance, the DNS and/or Medical records nurse is responsible for completion the Resident Mantoux CQI audit tool. This audit will occur weekly for 4 weeks, then bi-monthly for 2 months and quarterly until compliance is consistently met and maintained for 6 months. The results of these audits will be reviewed by the CQI committee. If the results of 100% is not achieved, the committee will create an action plan to ensure ongoing compliance.</p> |  |                            |

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|   | <p>#201 was reviewed on 7/26/12 at 9:20 A.M. Diagnoses included, but were not limited to, hypertension, diabetes, anemia, and aphasia.</p> <p>The resident was admitted to the facility on 4/20/12.</p> <p>The facility electronic [computer] health record indicated the admission 1st. Step P.P.D. skin test was administered on 4/21/12 and read on 4/23/12.</p> <p>During the daily conference on 7/26/12 at 3:50 P.M., the Director of Nursing was given the opportunity to submit any documentation demonstrating the resident received a P.P.D. test prior to, or upon, admission.</p> <p>At the final exit on 7/27/12 at 2:20 P.M., the Director of Nursing indicated she had no additional documentation related to a tuberculin skin test prior to, or upon, admission for this resident.</p> <p>4. On 7/23/12 at 1:45 P.M., Resident 33's record was reviewed. Diagnoses included, but were not limited to, renal failure, congestive heart failure, behaviors, and depression.</p> <p>Resident #33 was admitted to the facility</p> |  |  |  |                            |  |  |

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|   | <p>on 3/19/12.</p> <p>No documentation was located in Resident #33's clinical record for an admission tuberculin skin test.</p> <p>5. On 7/24/12 at 2:50 P.M., Resident #34's record was reviewed. Diagnoses included, but were not limited to, dementia, contractures, and left sided hemiplegia.</p> <p>Resident #34 was admitted to the facility on 3/7/11.</p> <p>A "Physician's Orders" dated July 2012, included, but was not limited to, "March PPD [tuberculin skin test]..."</p> <p>No documentation was located for Resident #34's clinical record for an annual tuberculin skin test completed in March 2012.</p> <p>6. On 7/25/12 at 2:30 P.M., Resident #28's record was reviewed. Diagnoses included, but were not limited to, frequent falls, confusion, and increased weakness.</p> <p>Resident # 28 was admitted to the facility on 6/7/12.</p> <p>No documentation was located in Resident #28's clinical record of an</p> |  |  |  |  |  |  |

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|   | <p>admission tuberculin skin test.</p> <p>7. On 7/25/12 at 2 :35 P.M., Resident #32's record was reviewed. Diagnoses included, but were not limited to, intellectual disabilities.</p> <p>Resident #32 was admitted to the facility on 12/18/06.</p> <p>A "Physician's Orders" dated July 2012, included, but was not limited to, "April PPD [tuberculin skin test]..."</p> <p>No documentation was located in Resident #32's clinical record of an annual tuberculin skin test completed in April 2012.</p> <p>8. On 7/26/12 at 1:50 P.M., in an interview with the DoN, she indicated she did not have the required tuberculin skin testing on the above residents. She indicated nursing staff are aware of the facility policy and procedures regarding tuberculin skin testing. The DoN indicated upon facility auditing, she was aware there was a concern with residents not getting tuberculin skin testing completed as per facility policy.</p> <p>9. On 7/26/12 at 1:50 P.M., the DoN provided the facility policy and procedure regarding TB [tuberculin] Screening.</p> |  |  |  |                            |  |  |

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|   | <p>The policy and procedure, dated 7/08, included, but was not limited to, "Policy: All residents either prior to or upon admission, in accordance with state and federal regulations will receive a 2-Step Mantoux test for tuberculosis... Resident Guidelines: Admission: Administer on day of admission per physician's order if resident has not had a documented negative Mantoux during the preceding 12 months... Annual: Administer annually..."</p> <p>3.1-18(e)</p> |  |  |  |  |  |                            |

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| F9999   | <p>STATE FINDINGS</p> <p>3.1-9 PERSONAL PROPERTY</p> <p>1. (g) The facility must inventory, upon admission and discharge, the personal effects, money, and valuables declared by the resident at the time of admission. It is the resident's responsibility to maintain and update the inventory listing of the resident's personal property.</p> <p>This State Rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to initiate an inventory of personal property for 2 of 6 residents admitted to the facility since the last Recertification survey ending on 6/17/11; in a sample of 24 residents reviewed. [Residents #17 and #201]</p> <p>Findings include:</p> <p>1. The clinical record for Resident #17 was reviewed on 7/26/12 at 11:20 A.M. Diagnoses included, but were not limited to, Parkinson's disease, diabetes, depression, and dementia.</p> <p>The resident was admitted to the facility</p> |  | F9999               | <p>F9999 Personal Property - It is the consistent practice of this Provider to initiate an inventory of personal property of each resident admitted.1. What Corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #17 - a personal inventory sheet was initiated, completed and updated. Resident #201 - no longer resides at facility2. How will this Provider identify other residents being affected by the same alleged deficient practice?All residents admitted to this facility have the potential to be affected by the alleged deficient practice.An audit was completed of current residents to identify and ensure an inventory sheet has been initiated and completed.3. What measures will be put into place and/or what systematic changes will be made to ensure that the alleged deficient practice does not recur?Admitting nursing staff will initiate and fill out an inventory sheet upon admission of each new resident. The Guest Relations Coordinator will review M-F each new admit to ensure an inventory sheet has been initiated and completed. The Guest Relations Coordinator will initiate an inventory of any new resident identified as missing or incomplete.4. How will the</p> |  | 08/26/2012                                 |  |

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|   | <p>on 3/2/12.</p> <p>An inventory sheet of the resident's personal property was not located in the hard copy/paper clinical record.</p> <p>In an interview on 7/26/12 at 1:15 P.M., the Staff Development Coordinator indicated the facility was still using a paper sheet to document each resident's personal property--the information was not yet being recorded in the electronic [computer] health records for residents.</p> <p>In an interview on 7/26/12 at 1:15 P.M., the Director of Nursing indicated the C.N.A.s were required to record personal items on the paper initially following admission, and then have the resident/family/responsible party sign.</p> <p>During the daily conference on 7/26/12 at 3:50 P.M., the Director of Nursing was given the opportunity to provided any documentation related to an personal property inventory upon admission for this resident.</p> <p>At the final exit on 7/27/12 at 2:20 P.M., the Director of Nursing indicated she had no further documentation related to the inventory.</p> <p>2. The closed clinical record for Resident</p> |  | <p>corrective action be monitored to ensure the alleged deficient practice does not recur?To ensure ongoing and consistent compliance, the DNS and/or Medical records nurse is responsible for completion of an Inventory Sheet CQI audit tool. This audit will occur weekly for 4 weeks, then bi-monthly for 2 months and quarterly until compliance is consistently met and maintained. The results of these audits will be reviewed by the CQI committee. If the results of 100% is not achieved, the committee will create an action plan to ensure ongoing compliance.</p> |  |  |  |  |

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|   | <p>#201 was reviewed on 7/26/12 at 9:20 A.M. Diagnoses included, but were not limited to, hypertension, diabetes, aphasia, and osteoporosis.</p> <p>The resident was admitted to the facility on 4/20/12.</p> <p>An inventory sheet of the resident's personal property was not located in the hard copy/paper clinical record.</p> <p>In an interview on 7/26/12 at 1:15 P.M., the Staff Development Coordinator indicated the facility was still using a paper sheet to document each resident's personal property--the information was not yet being recorded in the electronic [computer] health records for residents.</p> <p>In an interview on 7/26/12 at 1:15 P.M., the Director of Nursing indicated the C.N.A.s were required to record personal items on the paper initially following admission, and then have the resident/family/responsible party sign.</p> <p>During the daily conference on 7/26/12 at 3:50 P.M., the Director of Nursing was given the opportunity to provided any documentation related to an personal property inventory upon admission for this resident.</p> |  |                     |  |  |  |  |

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|   | <p>At the final exit on 7/27/12 at 2:20 P.M., the Director of Nursing indicated she had no further documentation related to the inventory.</p> <p>3.1-9(g)</p> |  |  |  |  |  |                            |